

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8209 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 09/15/2020 |
| NAME OF PROVIDER OR SUPPLIER HOLSTON MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| N 000 | Initial Comments Investigation of complaint #51989 was conducted on 9/14/2020 - 9/15/2020 at Holston Manor. No health deficiencies were cited under 1200-8-6, Standards for Nursing Homes. | N 000 | | |

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE